

PUGET SOUND

SURGICAL CENTER



PATIENT REGISTRATION WEIGHT LOSS SURGERY COMPREHENSIVE PROGRAM

Appointment Date: _____
Time: _____
Place: _____

NOTICE: This packet must be completed prior to your appointment time; to expedite your appointment please –

- ***Drop off or mail to office,***
- ***Email to regpacket@pssurgicalcenter.com or***
- ***Fax complete packet to the number below.***

Thank You

**Edmonds - 425-778-2220, Bellingham – 360-676-1111,
Toll-Free: 1-800-419-5750, Fax: 425-778-7701**

**21911 76th Ave W, STE 106, Edmonds, WA 98026
2930 Newmarket Street, Suite 115 Bellingham WA 98226**

PUGET SOUND

SURGICAL CENTER



PATIENT RECORD OF DISCLOSURES

NAME: _____ **BIRTHDATE:** _____

I wish to be contacted in the following manner (check all that apply):

Cellular Telephone Number _____

- OK to leave message on machine/voicemail, with detailed information
- OK to leave message with detailed information, with (specify name) _____
- Leave message with call-back number only

Home Telephone Number _____

- OK to leave message on machine/voicemail, with detailed information
- OK to leave message with detailed information, with (specify name) _____
- Leave message with call-back number only

Work Telephone Number _____

- OK to leave message on machine/voicemail, with detailed information
- OK to leave message with detailed information, with (specify name) _____
- Leave message with call-back number only

Written Communication

- OK to mail to my home address
- OK to mail to my work/office address
- OK to email to _____@_____
- OK to fax to this number _____

Other _____

Patient Signature

Date

Puget Sound Surgical Center Financial Policy

Welcome to our practice, please review and sign our financial policy.

We require payment pre-authorization for services to be rendered. Please complete the attached form, which will be securely kept on file for your convenience.

Referrals: If your insurance requires a referral, please bring that with you on your first visit.

Insurance Plans: As a courtesy to our patients, we will file your claims for you to your insurance company. If for some reason your insurance company declines to pay for the services rendered, then you, the patient, are responsible for the entire bill. Any co-pays, co-insurance and deductibles will be collected at the time of service.

Surgical Procedures: If you are to have surgery, our office will contact your insurance company for benefits and pre-authorization. Prior to the procedure being completed, our office will contact you regarding your financial responsibility. Any amounts due to PSSC from patient for surgeries are to be paid 1 (one) week prior to the scheduled procedure. If for some reason payment is not collected and/or other arrangements have not been made, then the surgical procedure will be postponed.

Labor and Industries: Labor and Industries patients are welcome. Since we are not primary care providers, a referral is required from your primary care doctor upon your first visit.

Self-Pay Patients: Payments are due at the time services are rendered. We may be able to give you an estimate over the phone, but please remember it is only an estimate. Charges will be determined once the patient has actually seen the doctor.

Forms: It is inevitable that forms unrelated to the filing of medical insurance claims, such as return to work and disability applications, time loss reports, and Family Medical Leave Act (FMLA) be provided by us. We will provide, free of charge, the first FMLA/disability form that a patient requires for each episode of surgery. Additional forms will be completed at a rate of \$20 per form. The fee MUST be paid in full at the time the form is dropped off. Please allow 5 business days for completion of forms.

Delinquent Accounts: Any accounts 90 days or older will be forwarded to our collection agency. The patient will be responsible for any fees incurred by PSSC to collect this debt. Fees include, but are not limited to, collection fees, attorney's charges and/or court fees incurred by PSSC.

Return Check Policy: There is a \$25.00 service fee on each returned check. A NSF check must be redeemed with cash within 5 business days of bank notification.

Minor Patients: An adult or legal guardian must accompany all minors to each office visit. The adult or legal guardian accompanying the minor assumes all financial responsibility for the cost of the minor's visit.

Attorney Protections/Letters of Guarantee: PSSC does not accept letters of guarantee from attorney offices.

If you cannot make your scheduled appointment time, please contact our office 24 hours prior to your appointment. If you cannot keep your surgery date or time, we require at least a 72 hour notification.

I have read and understand the above financial policy and agree to abide by the terms of this policy. For your convenience, PSSC accepts the following forms of payment: Visa, MasterCard, cash, check, money orders and cashier's checks.

Patient Signature

Date

revised 1/2010



APPOINTMENT/SURGERY CANCELLATION POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation/”No Show” of an Appointment

In order to be respectful of the medical needs of our patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment we require that you provide 24 hours notice. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Failure to provide 24 hours notice, or a “No Show” for an appointment will result in a **fee of \$50** to be billed to you for payment.

Cancellation/”No Show” for a surgery or procedure

Please provide a minimum of 48 hours notice to cancel or reschedule your surgery or procedure. Failure to provide a minimum of 48 hours notice to cancel or reschedule your surgery, or a “No Show” for your surgery will result in a **fee of \$300** to be billed to your account. Failure to provide a minimum of 48 hours notice to cancel or reschedule your procedure or a “No Show” for your procedure will result in a **fee of \$125** to be billed to your account.

Cancellation/”No Show” for Cosmetic Surgeries

Policy for Cosmetic Surgeries is as follows:

10% of the total fee if cancelled 4-8 days before surgery date

25% of the total fee if surgery is cancelled 3 days or less before the surgery date

Please call our office to cancel or reschedule your appointment at:

Edmonds location: 425.778.2220

Bellingham location: 360.676.1111

We understand that there may be unforeseen emergencies that may not allow for you to give the required notice, and exceptions to the policy may be made by management.

I have read and acknowledge receipt of the cancellation/No show policy

Printed Patient Name

Patient Signature

Date

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

We understand that information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose your health information. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by law
- To avert a serious threat to health and safety
- As required by the Military of Veterans and Worker Compensations
- Public Health Risks
- Health oversight activities
- Lawsuits and Disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Official for inmates

Your rights regarding health information about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosures
- Right to request a restriction
- Right to request confidential communication
- Right to a paper copy of this notice (full notice is available upon request).

Changes to this notice:

We reserve the right to change this notice. We will post a copy of this current notice in our facility with the current effected date on this page.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of receipt of this notice:

We will request that you sign a separate form acknowledging that you have received a copy of this notice. This acknowledgement will become part of your records.

NOTICE OF PRIVACY PRACTICE-ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practice.

Patient signature or legal authorized individual

Date

Printed name if signed on behalf of the patient

Relationship to patient

PATIENT RIGHTS AND RESPONSIBILITIES

This facility and medical staff have adopted the following list of patient rights and responsibilities. This list includes, but is not limited to:

PATIENT RIGHTS

- Impartial treatment without regard to race, color, sex, national origin, religion, handicap or disability.
- Considerate and respectful care at all times and under all circumstances.
- To receive care free from abuse.
- Knowledge of the name and professional status of those caring for you.
- To receive information from the surgeons about your diagnosis, treatment plan and prognosis to the best of the physicians' knowledge.
- To participate actively in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning your medical care program. Case discussion, examination and treatment are confidential and should be conducted discretely.
- To be informed that Advanced Directives cannot be honored at this facility and to be advised that should an unexpected life threatening event occur the patient will be transferred to a facility that will honor this directive.
- Confidential treatment of all communications and records pertaining to care. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with your care.
- Responsible responses to any reasonable request for service.
- To leave the facility even against medical advice.
- To expect reasonable continuity of care.
- To be advised if the physician proposes to engage in or perform experimentation affecting your care or treatment and the right to refuse to participate in this activity.
- To be informed of the continuing health care requirements following discharge from the center.
- Examine and receive an explanation of a bill for service, regardless of source of payment.
- To report any comments concerning the quality of care provided to you and expect follow-up on your comments.

PATIENT RESPONSIBILITIES

- To provide accurate and complete information concerning his/her present complaints, past medical history and other matters relating to their health.
- To notify us of the existence of an Advanced Directive (e.g. a living will) as those cannot be honored at this facility.
- To make it known whether he/she clearly comprehends the course of treatment and what is expected of him/her.
- For following the treatment plan established by the physician, including the instructions of nurses and other health care professional as they carry out the physicians' orders.
- For keeping his/her appointment and notifying the facility if unable to do so.
- To provide a responsible adult to drive them home and stay with them 24 hours after surgery.
- For assuring that the financial obligations of their care is fulfilled as promptly as possible.
- For being considerate of the rights of other patients and facility personnel.

PATIENT RIGHTS AND RESPONSIBILITIES (cont.)

FEEDBACK

Our goal is to provide the best surgical experience possible while in our Ambulatory Surgery Center. Patients, clients, families or visitors have the right to express complaints or concerns about any aspects of their care or experience with our ASC. Please be assured that expressing a complaint or concern will not compromise your care and will be addressed according to our policy. Concerns may be directed to any facility staff or the ASC Manager, or you may mail your comments to us.

If you feel it is necessary, complaints may also be shared with:

**MARY SELECKY, SECRETARY OF HEALTH
WASHINGTON STATE DEPARTMENT OF HEALTH
HEALTH SYSTEMS QUALITY ASSURANCE
COMPLAINT INTAKE
310 ISRAEL ROAD SE
P.O. BOX 47857
OLYMPIA, WA 98504-7857
360-236-4700
HSQAComplaintIntake@doh.wa.gov**

**OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN
OFFICE OF THE REGIONAL ADMINISTRATOR
DIVISION OF SURVEY AND CERTIFICATION OPERATIONS
CHRIS MARTIN, BRANCH MANAGER
2201 6TH AVENUE, SUITE 801
SEATTLE, WA 98121, 206-615-2313
1-800-MEDICARE (1-800-633-4227)
1-877-486-2048 (TTY)
www.medicare.gov**

STATEMENT OF PHYSICIAN FINANCIAL INTERESTS OR OWNERSHIP Your physician has an ownership interest in Puget Sound Surgical Center which includes the surgery center at which you are having your procedure. As with all of your care, you may request to have your procedure performed at another facility where your surgeon has privileges to practice.

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

Our **Patient Rights and Responsibilities** statement describes in more detail your rights and responsibilities as a patient of Puget Sound Surgical Center.

By my signature below I acknowledge receipt of the Patient Rights and Responsibilities statement.

Patient Signature or legally authorized individual

Date

Printed name if signed on behalf of the patient

Relationship to patient

Puget Sound Surgical Center

PATIENT NAME _____ BIRTHDATE ____/____/____

SOC. SEC. # ____/____/____ AGE _____ MALE FEMALE

Mailing Address _____ APT # _____

City _____ State _____ Zip _____ - _____ + 4 Email Address _____

HOME PHONE () _____ - _____ WORK PHONE () _____ - _____ CELL PHONE () _____ - _____

REFERRED BY _____ **PRIMARY CARE DR** _____

MARITAL STATUS: Single Married Widowed Divorced Separated Other _____

RACE (optional): Caucasian African American Hispanic Pacific Islander Asian
 Asian American American Indian Other _____

RESPONSIBLE PARTY: _____
(if other than patient) Name Date of Birth Relationship to patient

PATIENTS EMPLOYER _____ SPOUSES EMPLOYER _____

Full-Time Full-Time

OCCUPATION _____ Part-Time OCCUPATION _____ Part-Time

ADDRESS _____ ADDRESS _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

IN CASE OF EMERGENCY NOTIFY:

OKAY TO DISCLOSE INFORMATION

 Name Relationship Phone number YES NO

 Name Relationship Phone number YES NO

PREFERRED PHARMACY:

Pharmacy _____ Address _____

Phone _____ City, ST, Zip _____

How did you hear about us? _____

Signed _____ Date _____

Puget Sound Surgical Center

PRIMARY INSURANCE: _____ PLAN COPAYS\$ _____

Insurance Company Address: _____
Street or PO Box City, State Zip+4

Insurance Company Phone Number: _____

Subscriber ID #: _____ Group ID #: _____

Subscriber Name: _____ Relationship to the Patient: _____

Male Female Birth Date: _____ Soc. Sec.#: _____

Subscriber Employer: _____

SECONDARY INSURANCE: _____ PLAN COPAYS\$ _____

Insurance Company Address: _____
Street or PO Box City, State Zip+4

Insurance Company Phone Number: _____

Subscriber ID #: _____ Group ID #: _____

Subscriber Name: _____ Relationship to the Patient: _____

Male Female Birth Date: _____ Soc. Sec.#: _____

Subscriber Employer: _____

NOTES:

I hereby authorize my insurance benefits be paid directly to the physician. I also authorize the doctor or insurance company to release information required for this claim. I consent to the release of medical information from or to other doctors and healthcare institutions as is necessary to my care and treatment.

Payment: I am financially responsible for any balance due, I agree to make payment arrangements; pay \$5 per month on unpaid balances over 30 days and all the reasonable expenses such as attorney fees and court costs should account be referred for collections.

Signed _____ **Date** _____

BARIATRIC HEALTH HISTORY QUESTIONNAIRE

Puget Sound Surgical Center

Robert W. Landerholm, MD, FACS, ASBS

Peter S. Billing, MD, ASBS

Matthew R. Crouthamel, MD, FACS

Patient Name: _____

Address: _____

Home Phone: _____ Day Phone: _____ Cell Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Address: _____ Phone number: _____

Phone number: _____

Approximate Weight:

20 years ago: _____ 10 years ago: _____ 5 years ago: _____ 2 years ago: _____

1 year ago: _____ 6 months ago: _____

For Office Use Only

What age did you become obese? _____

IBW _____

What was your lowest adult weight? _____

% IBW _____

What was your highest adult weight? _____

Goal _____

What is your desired or goal weight? _____

Please describe your age and situation (major stress, if any) at the onset of your obesity:

WEIGHT LOSS PROGRAMS/DIETS/MEDICATIONS

Maximum weight loss on any program: _____

Maximum length of time you kept the weight off: _____

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Weight Watchers | <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Atkins |
| <input type="checkbox"/> Slimfast | <input type="checkbox"/> Nutrasystem | <input type="checkbox"/> Weight Mgt. Prog. |
| <input type="checkbox"/> Optifast | <input type="checkbox"/> Medifast | <input type="checkbox"/> Cambridge |
| <input type="checkbox"/> Metabolife | <input type="checkbox"/> Xenical | <input type="checkbox"/> Meridia |
| <input type="checkbox"/> Phen-Fen | <input type="checkbox"/> South Beach | <input type="checkbox"/> Redux |

Other Physician/Dietitian/Hospital supervised Programs:

office use

Age: _____ Height: _____ Weight: _____ BMI: _____

Measurements:

Waist: _____

Neck: _____

HAVE YOU HAD ANY OF THE FOLLOWING OBESITY RELATED PROBLEMS?

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Mellitus |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/GERD |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain/Arthritis/DJD |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea |
| <input type="checkbox"/> | <input type="checkbox"/> | Using CPAP/BIPAP - Setting _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is it working (CPAP/BIPAP) |

Other: _____

SURGERY

Please list all previous surgeries and hospitalizations:

Procedure/Diagnosis	Date	Hospital Name/Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ANESTHESIA

Please list any complications you have had with anesthesia:

_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS

Daily Aspirin: _____mg/day Daily Vitamins/Supplements: _____

Medications: Please list any medications you are presently taking: (including over-the-counter)

Medication	Dose	Frequency and time taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Do you have allergies to any medications? _____

If yes, please list the medications and the allergic reaction you experienced:

<u>Medication to which you are allergic</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PHARMACY

Preferred pharmacy: _____ Phone: _____
Address: _____ Fax: _____

MEDICAL HISTORY

Yes **No**

- Have you had a recent physical exam?
 If yes, Date _____
 Where/phone number: _____
- Have you had a recent chest X-ray?
 If yes, Date _____
 Where/phone number: _____
- Have you had a recent abdominal X-ray?
 If yes, Date _____
 Where/phone number: _____
- Have you had a recent EKG?
 If yes, Date _____
 Where/phone number: _____
- Have you had a recent blood and urine tests?
 If yes, Date _____
 Where/phone number: _____
- Have you had a recent echocardiogram (cardiac echo)?
 If yes, Date _____
 Where/phone number: _____
- Have you had a recent cardiac stress test?
 If yes, Date _____
 Where/phone number: _____
- Have you had a recent upper endoscopy?
 If yes, Date _____
 Where/phone number: _____
- Have you had a recent colonoscopy?
 If yes, Date _____
 Where/phone number: _____
- Have you had a recent sleep study?
 If yes, Date _____
 Where/phone number: _____

FOR WOMEN ONLY

- | | | | |
|--------------------------------------|--|-----------------------------|------------------------------|
| Date of last menstrual period: _____ | Are you pregnant now? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Date of last mammogram: _____ | <i>If yes, due date</i> _____ | | |
| Date of last PAP smear: _____ | Are you using any form of birth control? | <input type="checkbox"/> | <input type="checkbox"/> |
| Number of pregnancies: _____ | If yes, what type _____ | | |
| Number of live births: _____ | Are you taking hormone replacement? | <input type="checkbox"/> | <input type="checkbox"/> |
| | If yes, what type _____ | | |
| | Are your menstrual periods irregular? | <input type="checkbox"/> | <input type="checkbox"/> |
| | If yes, how often _____ | | |
| | Have you had hot flashes? | <input type="checkbox"/> | <input type="checkbox"/> |
| | If yes, date of onset _____ | | |

HABITS

Smoking

Have you ever smoked? Y/N Age Started _____ Age Quit _____

Are you currently a smoker? Y/N Number of packs per day _____

Beverages

How much of the following do you consume:

Beer _____ 12oz cans per week

Tea _____ cups per day

Wine _____ 4oz glasses per week

Coffee _____ cups per day

Liquor _____ 2oz drinks per week

Soda _____ cans per day *diet/regular*

Diet

Are you currently on a special diet? Y/N

If yes, please describe: _____

Where do you eat most of your meals?

- Home
- Restaurant
- Other _____

With whom do you usually eat?

- Alone
- Family
- Other _____

Who usually prepares the food you eat at home? _____

Please list any allergies or intolerances to food: _____

What are your favorite foods? _____

What eating habits do you have that bother you? _____

Social History

Occupation: _____

Marital Status: † Single † Married † Significant Other † Separated † Divorced † Widowed

Spouse/Significant Other Name: _____

Of Children _____ Names / Details

FAMILY HISTORY

Please indicate which, if any of your family members had the following conditions:

	Sibling	Mother	Father	Aunt/Uncle	Grandparent
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (breast)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (colon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is your father living? Y/N If not, cause of death _____, age of death _____

Is your mother living? Y/N If not, cause of death _____, age of death _____

Are any family members obese? Y/N List family member and approximate weight:

General

	Yes	No
Do you live alone?	<input type="checkbox"/>	<input type="checkbox"/>
Are you responsible for an invalid?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently involved in any lawsuit Related to an injury or operation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel pressed for time?	<input type="checkbox"/>	<input type="checkbox"/>

How often do you wake up in the middle of the night? _____

How often does your work leave you feeling exhausted? _____

GENERAL INFORMATION **briefly describe the following*

Household members: (Please include ages)

Please write about you! (Relationships, marriage, children, etc..)

How does your family feel about you having this surgery?

Please list your activities (out of home and work)

Please list major personal interests

How does your weight affect you socially?

How does your weight affect you physically?

Please list any publications which you frequently read (magazines, newspapers, etc..)

REVIEW OF SYSTEMS

CONSTITUTIONAL

- | Neg | Pos |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Good general health |
| <input type="checkbox"/> | <input type="checkbox"/> Unexplained weight change |
| <input type="checkbox"/> | <input type="checkbox"/> Fever |
| <input type="checkbox"/> | <input type="checkbox"/> Chills |
| <input type="checkbox"/> | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> Night sweats |

Other positives _____

EYES/EARS/NOSE/THROAT

- | Neg | Pos |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Disease or injury |
| <input type="checkbox"/> | <input type="checkbox"/> Glasses or contacts |
| <input type="checkbox"/> | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> | <input type="checkbox"/> Head trauma |
| <input type="checkbox"/> | <input type="checkbox"/> Vision changes |
| <input type="checkbox"/> | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> | <input type="checkbox"/> Ear drainage |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic rhinitis |
| <input type="checkbox"/> | <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> | <input type="checkbox"/> Voice change |
| <input type="checkbox"/> | <input type="checkbox"/> Lump in neck |

Other positives _____

CARDIOVASCULAR

- | Neg | Pos |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> Angina pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> | <input type="checkbox"/> Palpitations or racing heart |
| <input type="checkbox"/> | <input type="checkbox"/> Swelling of feet, ankles or hands |

Cardiac testing:

EKG date ____/____/____

Echo date ____/____/____

Stress Test date ____/____/____

Angiogram date ____/____/____

Other positives _____

RESPIRATORY

- | Neg | Pos |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> Coughing at night |
| <input type="checkbox"/> | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> Daytime sleepiness |
| <input type="checkbox"/> | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> | <input type="checkbox"/> Using CPAP/BIPAP |

Yes No Is CPAP/BIPAP working

Other positives _____

GASTROINTESTINAL

- | Neg | Pos |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> Painful bowel movements |
| <input type="checkbox"/> | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> Frequent diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> Black tarry stools |
| <input type="checkbox"/> | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> Loss of appetites |
| <input type="checkbox"/> | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> | <input type="checkbox"/> Peptic ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis |

Yes No Family history of colon cancer

Colonoscopy date ____/____/____

Upper Endoscopy date ____/____/____

Other positives _____

GENITOURINARY

- | Neg | Pos |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> | <input type="checkbox"/> Intermittent urinary stream |
| <input type="checkbox"/> | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> | <input type="checkbox"/> Sexual difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> Pain with periods |
| <input type="checkbox"/> | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> Vaginal discharge |

Pap smear date ____/____/____

of pregnancies _____

of miscarriages _____

Other positives _____

MUSCULOSKELETAL

- | Neg | Pos | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramping |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold extremities |
- Other positives _____

INTEGUMENTARY

- | Neg | Pos | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in nails |
| <input type="checkbox"/> | <input type="checkbox"/> | Suspicious moles or spots |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins |
- Other positives _____

BREAST

- | Neg | Pos | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Skin changes |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast lump |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Family Hist. of breast cancer |
- Who _____
 Mammogram date ____/____/____
 Other positives _____

NEUROLOGICAL

- | Neg | Pos | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Numb/tingling sensation |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Paralysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Blackouts/fainting |
- Other positives _____

PSYCHIATRIC

- | Neg | Pos | |
|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Memory loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia |
- Other positives _____

METABOLIC/ENDOCRINE

- | Neg | Pos | |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Gland/hormonal problem |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperthyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypothyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Diet controlled |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication controlled |
| <input type="checkbox"/> | <input type="checkbox"/> | Insulin controlled |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry skin |
- Other positives _____

HEMATOLOGIC

- | Neg | Pos | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Slow to heal after cuts |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding tendency |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruising tendency |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Pleuritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Past transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged glands |
- Other positives _____

ALLERGIC/IMMUNOLOGIC

- | Neg | Pos | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus/Autoimmune disorder |
- Skin or other adverse reaction to:
- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other antibiotics |
| <input type="checkbox"/> | <input type="checkbox"/> | Morphine, Demerol, or other narcotics |
| <input type="checkbox"/> | <input type="checkbox"/> | Novocaine or other anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin or other pain remedies |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus antitoxins or other serums |
| <input type="checkbox"/> | <input type="checkbox"/> | Iodine, Methiolate, or other antiseptic |
- Other drugs/medications _____
 Known food allergies _____
 Other positives _____

Patient Signature

Date



The STOP – BANG Questionnaire for OSA

The **STOP – BANG** test consists of eight questions:

S: Do you *snore* loudly? Yes No

T: Do you often feel *tired*, fatigued or sleepy during daytime even with a full night of sleep? Yes No

O: Has anyone *observed* you stop breathing during sleep? Yes No

P: Do you have or are you being treated for high blood *pressure*? Yes No

B: *BMI* more than 35kg/m²? (*calculator on next page) Yes No

A: *Age* over 50 years old? Yes No

N: *Neck* circumference greater than? (Male 17" Female 16") Yes No

G: *Gender* male? Yes No

Name of person completing questionnaire

Date

Body Mass Index Table

BMI	Height (in)																		
	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76
Wgt. (lbs)	4'10"	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"
100	21	20	20	19	18	18	17	17	16	16	15	15	14	14	14	13	13	13	12
105	22	21	21	20	19	19	18	18	17	16	16	16	15	15	14	14	14	13	13
110	23	22	22	21	20	20	19	18	18	17	17	16	16	15	15	15	14	14	13
115	24	23	23	22	21	20	20	19	19	18	18	17	17	16	16	15	15	14	14
120	25	24	23	23	22	21	21	20	19	19	18	18	17	17	16	16	15	15	15
125	26	25	24	24	23	22	22	21	20	20	19	18	18	17	17	17	16	16	15
130	27	26	25	25	24	23	22	22	21	20	20	19	19	18	18	17	17	16	16
135	28	27	26	26	25	24	23	23	22	21	21	20	19	19	18	18	17	17	16
140	29	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18	17
145	30	29	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18
150	31	30	29	28	27	27	26	25	24	24	23	22	22	21	20	20	19	19	18
155	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	20	20	19	19
160	34	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	21	20	20
165	35	33	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	21	20
170	36	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21
175	37	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	22	21
180	38	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	22
185	39	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23
190	40	38	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23
195	41	39	38	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24
200	42	40	39	38	37	36	34	33	32	31	30	30	29	28	27	26	26	25	24
205	43	41	40	39	38	36	35	34	33	32	31	30	29	29	28	27	26	26	25
210	44	43	41	40	38	37	36	35	34	33	32	31	30	29	29	28	27	26	26
215	45	44	42	41	39	38	37	36	35	34	33	32	31	30	29	28	28	27	26
220	46	45	43	42	40	39	38	37	36	35	34	33	32	31	30	29	28	28	27
225	47	46	44	43	41	40	39	38	36	35	34	33	32	31	31	30	29	28	27
230	48	47	45	44	42	41	40	38	37	36	35	34	33	32	31	30	30	29	28
235	49	48	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	29	29
240	50	49	47	45	44	43	41	40	39	38	37	36	35	34	33	32	31	30	29
245	51	50	48	46	45	43	42	41	40	38	37	36	35	34	33	32	32	31	30
250	52	51	49	47	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30
255	53	52	50	48	47	45	44	43	41	40	39	38	37	36	35	34	33	32	31
260	54	53	51	49	48	46	45	43	42	41	40	38	37	36	35	34	33	33	32
265	56	54	52	50	49	47	46	44	43	42	40	39	38	37	36	35	34	33	32
270	57	55	53	51	49	48	46	45	44	42	41	40	39	38	37	36	35	34	33
275	58	56	54	52	50	49													

BMI Category	Medical Classification	Health Risk Based on BMI	Health Risk if You Have Obesity-Related Complications
18-24.9	Ideal	Minimal	Low
25-26.9	Overweight	Low	Moderate
27-29.9	Overweight	Moderate	High
30-34.9	Obese	High	Very High
35-39.9	Severely Obese	Very High	Extremely High
40 and above	Morbidly Obese	Extremely High	Extremely High

To calculate exact BMI:

The person's weight in pounds and height in inches: $BMI = (\text{pounds} \times 700) \div (\text{inches squared})$



GERD Questionnaire

Name: _____ **DOB:** ___/___/___ **Date:** ___/___/___

*Circle the number to the right of each question which best describes your experience over the past **2 weeks***

Scale:

0 = No symptom

1 = Symptoms noticeable but not bothersome

2 = Symptoms noticeable and bothersome but not every day

3 = Symptoms bothersome every day

4 = Symptoms affect daily activity

5 = Symptoms are incapacitating to do daily activities

- | | | | | | | | |
|-----|---|---|---|---|---|---|---|
| 1. | How bad is the heartburn? | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. | Heartburn when lying down? | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. | Heartburn when standing up? | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. | Heartburn after meals? | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. | Does heartburn change your diet? | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. | Does heartburn wake you from sleep? | 0 | 1 | 2 | 3 | 4 | 5 |
| 7. | Do you have difficulty swallowing? | 0 | 1 | 2 | 3 | 4 | 5 |
| 8. | Do you have pain with swallowing? | 0 | 1 | 2 | 3 | 4 | 5 |
| 9. | If you take medication, does this affect your daily life? | 0 | 1 | 2 | 3 | 4 | 5 |
| 10. | How bad is the regurgitation? | 0 | 1 | 2 | 3 | 4 | 5 |
| 11. | Regurgitation when lying down? | 0 | 1 | 2 | 3 | 4 | 5 |
| 12. | Regurgitation when standing up? | 0 | 1 | 2 | 3 | 4 | 5 |
| 13. | Regurgitation after meals? | 0 | 1 | 2 | 3 | 4 | 5 |
| 14. | Does regurgitation change your diet? | 0 | 1 | 2 | 3 | 4 | 5 |
| 15. | Does regurgitation wake you from sleep? | 0 | 1 | 2 | 3 | 4 | 5 |
| 16. | How satisfied are you with your present condition? | 0 | 1 | 2 | | | |

0 = Satisfied 1 = Neutral 2 = Dissatisfied



GSRs Questionnaire

Name: _____ DOB: ___/___/___ Date: ___/___/___

Please answer every question by circling **ONLY ONE** response that best describes how you have felt during the past **2 weeks**.

1. **Heartburn.** Representing retrosternal discomfort or burning sensation.

a. How much has heartburn bothered you on a daily basis?

Not at all 1	Intermittently 2	Moderately 3	Severely 4
-----------------	---------------------	-----------------	---------------

b. How often have you experienced heartburn?

Never 0	Once a month 1	Once a week 2	2-4 times a week 3	Daily 4
------------	-------------------	------------------	-----------------------	------------

2. **Regurgitation.** Representing sudden regurgitation of acid gastric content.

a. How much has regurgitation bothered you on a daily basis?

Not at all 1	Intermittently 2	Moderately 3	Severely 4
-----------------	---------------------	-----------------	---------------

b. How often have you experienced regurgitation?

Never 0	Once a month 1	Once a week 2	2-4 times a week 3	Daily 4
------------	-------------------	------------------	-----------------------	------------

3. **Abdominal distention.** Representing bloating with abdominal gas.

a. How much has epigastric fullness bothered you on a daily basis?

Not at all 1	Intermittently 2	Moderately 3	Severely 4
-----------------	---------------------	-----------------	---------------

b. How often have you experienced epigastric fullness?

Never 0	Once a month 1	Once a week 2	2-4 times a week 3	Daily 4
------------	-------------------	------------------	-----------------------	------------

4. **Dysphagia.** Representing painful swallowing or the sensation of a lump in the throat.

a. How much has dysphagia bothered you on a daily basis?

Not at all 1	Intermittently 2	Moderately 3	Severely 4
-----------------	---------------------	-----------------	---------------

b. How often have you experienced dysphagia?

Never 0	Once a month 1	Once a week 2	2-4 times a week 3	Daily 4
------------	-------------------	------------------	-----------------------	------------

5. **Coughing.** Representing the need to expel air from the lungs suddenly and noisily, often to keep the respiratory passages free of irritating material.

a. How much has coughing bothered you on a daily basis?

Not at all 1	Intermittently 2	Moderately 3	Severely 4
-----------------	---------------------	-----------------	---------------

b. How often have you coughed?

Never 0	Once a month 1	Once a week 2	2-4 times a week 3	Daily 4
------------	-------------------	------------------	-----------------------	------------

Reference

Allen CJ, Parameswaran K, Belda J, Anvari M. "Reproducibility, validity, and responsiveness of a disease-specific symptom questionnaire for gastroesophageal reflux disease." *Diseases of the Esophagus* 2000; 13:265-270.